Use the following chart to determine UTI selection for EHH Medicare Notices:

UTI	UTI Language	Select on:
MHP056	__F1__ entitled to Medicare because __F2__ medically affected from exposure to a public health hazard in an area subject to an emergency declaration. FILL-IN VALUES: Fill-in 1: 1. You are 2. BENEFICIARY NAME is Fill-in 2: 1. you are 2. she is 3. he is	Notice of Award; Important Information notice
MHP057	You asked us to take another look at __F1__ claim for Medicare based on exposure to a public health hazard in an area subject to an emergency declaration. Someone who did not make the first decision reviewed __F2__ case, including any new facts you gave us. To get this type of Medicare coverage, __F3__ must meet both medical and presence rules. After our review, we found that __F4__ entitled to Medicare because __F5__ both of these rules. FILL-IN VALUES: Fill-in 1: 1. your 2. BENEFICIARY NAME's 3. BENEFICIARY NAME' Fill-in 2: 1. your 2. her 3. his Fill-in 3: 1. you	Notice of Reconsideration (reversal)

	2. she 3. he Fill-in 4: 1. you are 2. she is 3. he is Fill-in 5: 1. you meet 2. she meets 3. he meets	
CAP2	**What We Will Pay**	when selecting G16
G16	• The next check you receive will be for __F1__, which is the money you are due through __F2__. __F3__ • Your next scheduled payment of __F4__ which is for __F5__, will be received on or about the __F6__ of __F7__. • After that, you will receive __F8__ on or about the __F9__ of each month. FILL-IN VALUES: Fill-in 1: Complete with the check amount. Fill-in 2: Complete with the month and year. Fill-in 3: Optional bullet item. If blank, the second bullet item will not generate. If not blank, the second bullet item will generate. Fill-in 4: Complete with the money amount. Fill-in 5: Complete with the month and year.	when the beneficiary is newly entitled to Part B (whether or not they have Part A), and Part B premiums will be deducted from monthly SSA benefits

	Fill-in 6: The day of the month that continuing payments will be made Fill-in 7: Complete with the month and year. Fill-in 8: Complete with the money amount. Fill-in 9: The day of the month that continuing payments will be made	
HIBC01	**Information About Medicare**	on all notices
MHP059	__F1__ already entitled to Medicare. There are no changes in the effective dates of __F2__ hospital insurance (Part A) and medical insurance (Part B). FILL-IN VALUES: Fill-in 1: 1. You are 2. She is 3. He is Fill-in 2: 1. your 2. her 3. his	when the beneficiary is currently entitled to Medicare Parts A and B and the beneficiary does not have Medicare through the RRB
MHP060	__F1__ already entitled to Medicare. There is no change in the effective date of __F2__ hospital insurance (Part A). __F3__ medical insurance (Part B) beginning __F4__. __F5__ monthly medical insurance (Part B) premium is __F6__. FILL-IN VALUES: Fill-in 1: 1. You are 2. She is 3. He is Fill-in 2: 1. your 2. her	when the beneficiary is currently entitled to Part A and is newly entitled to Part B and the beneficiary does not have Medicare through the RRB

	3. his Fill-in 3: 1. You now have 2. She now has 3. He now has Fill-in 4: Complete with the month and year when Part B entitlement begins. Fill-in 5: 1. Your 2. Her 3. His Fill-in 6: Complete with the amount of the Part B premium	
H10	You are entitled to hospital insurance under Medicare beginning __F1__. FILL-IN VALUES: Fill-in 1: Complete with the month and year when Part A coverage begins.	when the beneficiary is newly entitled to Part A and, if entitled to Part B, the Part A and B coverage begins in different months
H12	You are entitled to medical insurance under Medicare beginning __F1__. FILL-IN VALUES: Fill-in 1: Complete with the month and year when Part B coverage begins.	when the beneficiary is newly entitled to Part A and Part B, and the coverage begins in different months
H11	You are entitled to hospital and medical insurance under Medicare beginning __F1__. FILL-IN VALUES: Fill-in 1: Complete with the month and year when Part A and B coverage begins.	when the beneficiary is newly entitled to Part A and Part B and the coverage begins in the same month
H49	If you want to have these benefits earlier, you can choose medical insurance benefits beginning __F1__. If	when the beneficiary is

	you want this benefit to start earlier, you must do the following things within 60 days after the date of this notice: • tell us in writing that you want medical insurance benefits beginning __F2__; • pay us $__F3__. This covers the premiums due from __F4__ through __F5__; or • tell us we can withhold this amount from the check. If you want the benefits beginning __F6__ but would find it hard to pay the premium amount in a lump sum, ask us about other ways to pay the money. FILL-IN VALUES: Fill-in 1: Complete with earlier SMI entitlement date Fill-in 2: Complete with earlier SMI entitlement date Fill-in 3: Complete with amount of SMI premium from earlier date Fill-in 4: Complete with earlier SMI entitlement date Fill-in 5: Complete with month prior to COM Fill-in 6: Complete with earlier SMI entitlement date	newly entitled to Part B and untimely processing of Part B
MHP061	Our records show that you have Medicare through the Railroad Retirement Board (RRB). Since you already have Medicare under your Railroad claim number, you should continue using that number.	when beneficiary already has Medicare coverage through the RRB
HIB005	The monthly __F1__ for __F2__ medical insurance __F3__ $__F4__ __F5__. FILL-IN VALUES:	when the beneficiary is newly entitled to Part B and is not already entitled to

	Fill-in 1: 1. premium 2. premiums Fill-in 2: 1. your 2. her 3. his Fill-in 3: 1. is 2. are Fill-in 4: 1. MONEY FILL beginning MONTH YEAR 2. Null Fill-in 5: 1. MONEY FILL beginning MONTH YEAR and MONEY FILL beginning MONTH YEAR 2. Null	Part A and the beneficiary does not have Medicare through the RRB
HIB009	We will send your first bill for the premiums within a month. Each bill will be for a 3-month period.	when the beneficiary is newly entitled to Part B and premiums are not deducted from monthly benefits and the beneficiary does not have Medicare through the RRB
H64	We are taking medical insurance premiums due through __F1__ out of the check you will receive around __F2__. These premiums total $__F3__. We will deduct medical insurance premiums 1 month in advance. FILL-IN VALUES: Fill-in 1: Complete with the month and year. Fill-in 2: Complete with the month and year.	when the beneficiary is newly entitled to Part B and premiums are deducted from monthly benefits and the beneficiary does not have Medicare through the RRB

	Fill-in 3: Complete with the money amount.	
HIB002	We will send __F1__ a Medicare card. __F2__ should take this card with __F3__ when __F4__ __F5__ medical care. If __F6__ __F7__ medical care before receiving the card and __F8__ coverage has already begun, use this letter as proof that __F9__covered by Medicare. FILL-IN VALUES: Fill-in 1: 1. Beneficiary's name 2. him 3. her 4. you Fill-in 2: 1. Beneficiary's name 2. He 3. She 4. You Fill-in 3: 1. Beneficiary's name 2. him 3. her 4. you Fill-in 4: 1. Beneficiary's name 2. he 3. she 4. you Fill-in 5: 1. need 2. needs Fill-in 6: 1. Beneficiary's name 2. he 3. she 4. you Fill-in 7:	when the beneficiary is newly entitled to Part A, Part B, or Part A and Part B and does not have Medicare through the RRB

	1. need 2. needs Fill-in 8: 1. Beneficiary's name 2. his 3. her 4. you Fill-in 9: 1. Beneficiary's name is 2. he is 3. she is 4. you are	
HIB052	If you do not want medical insurance, please complete the enclosed card and return it to us in the envelope we have provided. You will need to do this by the date shown on the card. If you decide you do not want the insurance, we will return any premiums that you have paid.	when the beneficiary is newly entitled to Part B and wants to refuse coverage and the beneficiary does not have Medicare through the RRB
HIB186	IMPORTANT: A new law changes how premiums for Medicare Part B are calculated for some higher income beneficiaries, generally individuals with incomes higher than $__F1__ and couples with incomes higher than $__F2__. Social Security will be contacting the Internal Revenue Service, and if we determine that __F3__ to pay a higher premium, we will send __F4__ a notice explaining our decision, and the higher amount will be effective __F5__. For more information, visit www.socialsecurity.gov on the Internet or call us toll-free at 1-800-772-1213 (TTY 1-800-325-0778). FILL-IN VALUES: Fill-in 1: MONEY FILL Fill-in 2: MONEY FILL Fill-in 3: 1. he has	when the beneficiary is newly entitled to Part B and the beneficiary does not have Medicare through the RRB

	2. she has 3. you have Fill-in 4: 1. him 2. her 3. you Fill-in 5: DATE FILL	
MPDC19	**Medicare Prescription Drug Plan**	when selecting MHP053
MHP053	Now that __F1__ __F2__ eligible for Medicare, __F3__ can enroll in a Medicare prescription drug plan (Part D). To learn more about the Medicare prescription drug plans and when __F4__ can enroll, visit www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048). Medicare also can tell __F5__ about agencies in __F6__ area that can help __F7__ choose __F8__ prescription drug coverage. If __F9__ limited income and resources, we encourage __F10__ to apply for the Extra Help that is available to assist with Medicare prescription drug costs. The Extra Help can pay the monthly premiums, annual deductibles and prescription co-payments. To learn more or apply, please visit www.socialsecurity.gov, call 1-800-772-1213 (TTY 1-800-325-0778) or visit the nearest Social Security office. FILL-IN VALUES: Fill-in 1: 1. Beneficiary's name 2. you Fill-in 2: 1. is 2. are Fill-in 3: 1. he 2. she 3. you	when the beneficiary is not enrolled in Part D and does not already have Medicare Part A and B

	Fill-in 4: 1. he 2. she 3. you Fill-in 5: 1. him 2. her 3. you Fill-in 6: 1. his 2. her 3. your Fill-in 7: 1. him 2. her 3. you Fill-in 8: 1. his 2. her 3. your Fill-in 9: 1. he has 2. she has 3. you have Fill-in 10: 1. him 2. her 3. you	
CLOC01	**Other Social Security Benefits**	all notices
CLO002	The __F1__ described in this letter __F2__ __F3__ can receive from Social Security. If you think that __F4__ might qualify for another kind of Social Security benefit in the future, you will have to file another application. FILL-IN VALUES: Fill-in 1: 1. benefit 2. benefits	all notices

	Fill-in 2: 1. is the only one 2. are the only one Fill-in 3: 1. you 2. he 3. she Fill-in 4: 1. you 2. he 3. she	
ALSC02	**Do You Disagree With The Decision?**	all notices
ALS187	If you disagree with this decision, you have the right to appeal. We will review __F1__ case and consider any new facts you have. A person who did not make the first decision will decide __F2__ case. We will correct any mistakes. We will review those parts of the decision which you believe are wrong and will look at any new facts you have. We may also review those parts which you believe are correct and may make them unfavorable or less favorable to __F3__. • You have 60 days to ask for an appeal. • The 60 days start the day after you receive this letter. We assume you got this letter 5 days after the date on it unless you show us that you did not get it within the 5-day period. • You must have a good reason for waiting more than 60 days to ask for an appeal. • You can file an appeal with any Social Security office. You must request the appeal in writing. Please use our “Request for Reconsideration” form, SSA-561, which is available on our website at www.socialsecurity.gov on the Internet. You can also contact us by phone, by mail, or come into the office to obtain the form. If you need assistance, we can help you fill out the form. Please read the enclosed pamphlet, "Your Right to Question the Decision Made on Your Claim". It contains more information about the appeal.	Notice of Award; Important Information notice

	FILL-IN VALUES: Fill-in 1: 1. your 2. her 3. his Fill-in 2: 1. your 2. her 3. his Fill-in 3: 1. you 2. her 3. him	
ALS188	If you disagree with the decision, you have the right to request a hearing. At the hearing, a person who has not seen __F1__ case before will look at it. That person is an Administrative Law Judge. In the rest of our letter, we will call this person an ALJ. The ALJ will review those parts of the decision which you believe are wrong. The ALJ will look at any new facts you have and correct any mistakes. The ALJ may also review those parts which you believe are correct and may make them unfavorable or less favorable to __F2__. • You have 60 days to ask for an appeal. • The 60 days start the day after you receive this letter. We assume you got this letter 5 days after the date on it unless you show us that you did not get it within the 5-day period. • You must have a good reason for waiting more than 60 days to ask for an appeal. • You can file an appeal with any Social Security office. You must request the appeal in writing. Please use our "Request for Hearing" form, HA-501-U5, which is available on our website at www.socialsecurity.gov on the Internet. You can also contact us by phone, by mail, or come into	on Notice of Reconsideration (reversal)

	the office to obtain the form. If you need assistance, we can help you fill out the form. Please read the enclosed pamphlet, "Your Right to An Administrative Law Judge Hearing and Appeals Council Review of Your Social Security Case." It contains more information about the hearing. FILL-IN VALUES: Fill-in 1: 1. your 2. her 3. his Fill-in 2: 1. you 2. her 3. him	
REPC01	**If You Want Help With Your Appeal**	all notices
REP002	You can have a friend, representative, or someone else help you. There are groups that can help you find a representative or give you free legal services if you qualify. There are also representatives who do not charge unless you win your appeal. Your Social Security office has a list of groups that can help you with your appeal. If you get someone to help you, you should let us know. If you hire someone, we must approve the fee before he or she can collect it.	all notices
REFC01	**If You Have Any Questions**	all notices
REF133	If you have any questions about Medicare eligibility based on exposure to a public health hazard, please call us toll-free at 1-__F1__-__F2__-__F3__ or write to us at: __F4__ __F5__ __F6__ __F7__ __F8__ FILL-IN VALUES:	all notices

	Fill-in 1: For Libby cases, complete with area code “888” Fill-in 2: For Libby cases, complete with phone exchange “482” Fill-in 3: For Libby cases, complete with phone number “3128” Fill-ins 4-6: For Libby cases, complete with: 275 Corporate Drive Ashley Square Mall Suite D Fill-in 7: For Libby cases, complete with “Kalispell, MT” Fill-in 8: For Libby cases, complete with zip code “59901”	
CTDO	We invite you to visit our website at www.socialsecurity.gov on the Internet to find general information about Social Security. If you have any specific questions, you may call us toll-free at 1-800-772-1213, or call your local Social Security office at 1-__F1__-__F2__ - __F3__. We can answer most questions over the phone. If you are deaf or hard of hearing, you may call our TTY number, 1-800-325-0778. You can also write or visit any Social Security office. The office that serves your area is located at: __F4__ __F5__ __F6__ __F7__ __F8__-__F__9__ If you do call or visit an office, please have this letter with you. It will help us answer your questions. Also, if you plan to visit an office, you may call ahead to make an appointment. This will help us serve you more quickly when you arrive at the office. FILL-IN VALUES: Fill-in 1:	all notices

	Complete with servicing field office phone are code Fill-in 2: Complete with servicing field office phone exchange Fill-in 3: Complete with servicing field office phone number Fill-ins 4-9: Complete with servicing field office address	
	Enclosures: Pub 05-10058 (Award Notice and Important Information notice) Pub 07-10281 (Notice of Reconsideration) CMS-2690 Return Envelope	